Colleague Giving Donation Form

Stmhfoundation@trinityhealthofne.org or 203-709-6390

STEP 1: Colleague Information

Name:______________________________

Address:____________________________

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Colleague ID #: _______________________

Phone:______________________________

Email:______________________________

Department:__________________________

STEP 2: Designation

- ❑ Saint Mary's Area of Greatest Need
- ❑ Emergency Department Renovations
- ❑ Colleague Scholarship Fund
- ❑ Nursing Education
- ❑ Breast Screening Fund
- ❑ Medical Residency Program

❑ I want my gift to honor a colleague:

Name:____________________________Department:__________________________________

STEP 3: Contribution

Payroll Deduction

○ Per paycheck (every two weeks):

☐ $20 ☐ $10 ☐ $4 ☐ $2 ☐ Other:_________

○ Onetime Deduction:

☐ $500 ☐ $250 ☐ $100 ☐ $50 ☐Other:______

☐ *I understand deductions will rollover year to year unless I notify the Foundation at 203-709-6390 or complete a new donation form.*

❑ **Cash or Check $**_____________

*Payable to **Saint Mary's Hospital Foundation***

❑ **Credit Card:** $ ______________________

Credit Card #:__________________________

CVV Code:_____Exp. Date: _______________

○ **Change** my current deduction per paycheck (every two weeks) as of_____________(Date) to $_________________

STEP 4: Appreciation Gift

Gifts of $100 or more receive a "be inspired" long-sleeve t-shirt: ☐ mens ☐ ladies

☐ Small ☐ Medium ☐ Large ☐ X-Large ☐ 2XL ☐ 3XL ☐ no gift, thank you

STEP 5: Submit - Saint Mary's Hospital Foundation -stmhfoundation@trinityhealthofne.org

Signature *(required)*:____Date: ________________________

❑ I am interested in including the hospital in my will or life insurance. Please contactme.

❑ I wish to remain anonymous on any publication of donors.

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